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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNIFER ANN WILSON, M.D.** Community Health Clinic OLE 1141 Pear Tree Lane, Suite 100 Napa, CA 94558 Physician's and Surgeon's Certificate No. A 86620, Respondent.	Case No. 800-2017-035705 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 2, 2004, the Medical Board issued Physician's and Surgeon's Certificate Number A 86620 to Jennifer Ann Wilson, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed.

3. At all times alleged herein, Respondent was board-certified in Family Medicine and worked at the Community Health Clinic OLE ("Clinic OLE") in Napa, California.

JURISDICTION

4. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not

apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2228 of the Code states, in pertinent part:

"The authority of the board . . . to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

"(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

"(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

"(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

"(d) Providing the option of alternative community service in cases other than violations relating to quality of care."

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

9. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS

10. Alprazolam, known by the trade name Xanax, is a psychotropic triazolo-analogue of the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment.

11. Diazepam, known by the trade name Valium, is a psychotropic drug of the benzodiazepine class that is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

12. Gabapentin, known by the trade name Neurontin, is an anticonvulsant that is used to prevent and control seizures and is also used to relive nerve pain, peripheral neuropathy. It is a dangerous drug as defined in Business and Professions Code section 4022.

13. Hydrocodone bitartrate with acetaminophen, which is known by the trade names Norco or Vicodin, is a semi-synthetic opioid analgesic. It is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code, and by section 1308.13

(e) of Title 21 of the Code of Federal Regulations[1], and is a dangerous drug as defined in Business and Professions Code section 4022.

14. Methadone hydrochloride is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine.

15. Seroquel, a trade name for quetiapine fumarate, is an antipsychotic drug that is sedating and is used to treat mental/mood disorders such as schizophrenia, major depressive disorder, and bipolar disorder. It is a dangerous drug as defined in Business and Professions Code section 4022.

16. Temazepam, known by the trade name Restoril, is a benzodiazepine hypnotic agent used in the short-term treatment of insomnia symptoms. It is a Schedule IV controlled substance and narcotic as defined by section 11057 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

17. Zolpidem tartrate, known by the trade name Ambien, is a non-benzodiazepine central nervous system (CNS) depressant of the imidazopyridine class. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(32), and is a dangerous drug as defined in Business and Professions Code section 4022. It is indicated for the short-term treatment of insomnia. It is a CNS depressant and should be used cautiously in combination with other CNS depressants. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

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[1] Effective 10/06/2014, all hydrocodone combination products were re-scheduled from Schedule III to Schedule II controlled substances by the Federal Drug Enforcement Agency ("DEA"), section 1308.12 (b)(1)(vi) of Title 21 of the Code of Federal Regulations.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts and/or Excessive Prescribing and/or Prescribing without Appropriate Examination: Patient A.)

18. Respondent is subject to disciplinary action for unprofessional conduct for gross negligence and/or repeated acts of negligence and/or prescribing without appropriate prior examination and medical indications and/or repeated acts of clearly excessive prescribing, under sections 2234, subd. (b) and/or 2234, subd. (c) and/or 2242 and/or 725, as described herein below.

19. In or about October 2006, Respondent began treating Patient A for chronic pain syndrome. The patient's chronic pain arose from a work-related injury that nearly amputated his leg. Patient A also had a history of alcohol abuse and suffered from major depression and anxiety.

20. In or about January 2007, Patient A began participating in a monthly Chronic Pain Management Support Group at Clinic OLE that included monthly visits with Respondent.

21. During the course of Patient A's treatment, Respondent prescribed methadone in combination with other controlled substances while Patient A was also struggling with alcohol abuse.

22. From about October 2009 to November 2010, Patient A moved from Napa County to Lake County and received treatment and controlled substances from another physician in Lake County.

23. On or about February 7, 2012, Respondent saw Patient A and prescribed to him multiple controlled substances: #150 Norco 10-325 mg., #150 Methadone HCl 10 mg., #90 Ibuprofen 800 mg. Respondent stopped prescribing Valium 5 mg. and prescribed #60 Temazepam. Respondent referred Patient A to a Licensed Clinical Social Worker, a behavioral health consultant, because he was struggling with alcohol abuse and depressive symptoms.

24. On or about February 13, 2012, Patient A saw a Licensed Clinical Social Worker ("LCSW") at the Clinic OLE. During that session, Patient A disclosed that, four months earlier he had attempted suicide with a gun and that he had a history of alcohol and of marijuana abuse.

25. On or about July 24, 2012, Respondent saw Patient A who was complaining of increased knee pain. Respondent noted that the patient reported that his last alcoholic drink was five weeks ago and that he had been arrested for having an altered firearm, a shotgun. Respondent continued to prescribe monthly for Patient A: #150 Methadone 10 mg., #120 Norco 10-325 mg., #60 Temazepam 30 mg., and #90 Ibuprofen 800 mg. Respondent also added a prescription for Gabapentin 100 mg.

26. On or about August 2, 2012, Patient A saw the LCSW about his depression. The LCSW noted in the patient's chart a diagnosis of Psychotic Disorder NOS.

27. On or about August 14, 2012, Respondent saw Patient A and noted in his chart that it was unclear whether his Psychotic Disorder NOS was "substance-abuse related or true mental illness." Respondent noted that the patient began to drink alcohol at age 13 and consistently consumed alcohol for 40 years. Although Respondent mentioned in the chart note that she discussed with the patient how each prescribed medication worked, she did not document a discussion about the dangers of a potential overdose should he drink alcohol while consuming the combination of prescribed drugs. Respondent refilled prescriptions for #150 Methadone, #120 Norco 10-325 mg., Ibuprofen 800 mg., and #90 Gabapentin 100 mg. Respondent also added a prescription for #30 Seroquel 200 mg. with three refills.

28. On or about September 4, 2012, Respondent saw Patient A as part of his monthly chronic pain group session. Respondent continued to prescribe Gabapentin 100 mg., Ibuprofen 800 mg., Temazepam 30 mg., #180 Methadone HCl 10 mg., and #120 Norco 10-325 mg., and #30 Risperdal 3 mg. Respondent noted that the patient agreed to meet with a consulting psychiatrist "for clarification of diagnosis." Respondent also noted that the patient reported that he could not afford the Seroquel and did not get the Risperdal prescription.

29. On or about September 12, 2012, Respondent saw Patient A for a psychiatric consultation. Respondent noted a discussion with the consultant psychiatrist at Clinic OLE who agreed that the patient was exhibiting psychotic symptoms and agreed with using Seroquel and avoiding all benzodiazepines. Patient A asked for a prescription for Xanax because he had tried some of his friend's supply and felt great. Respondent noted that she reiterated that he was to

avoid all benzodiazepines "given his extensive struggle with alcohol." Respondent also noted that the patient was to start Seroquel and avoid all other sleep aids. Respondent prescribed #60 Seroquel 100 mg. with three refills and noted that she was stopping the Risperdal 3 mg. and Temazepam 30 mg.

30. In August 2012, Respondent documented reviewing a CURES report for Patient A and obtaining a urine toxicology screen, which did not include a test for alcohol.

31. On or about January 8, 2013, Respondent next saw Patient A who reported that he did not want to take Norco. Respondent increased the prescription of Methadone to #180 Methadone 10 mg., and added a prescription for #30 Zolpidem tartrate 12.5 mg. extended release. Patient A was also still taking Gabapentin 100 mg., Ibuprofen 800 mg., and Seroquel 100 mg. Respondent noted that the "patient will price the sleep aid and purchase whichever is most affordable, pharmacy instructed to void other Rx."

32. In January, February, April, and May 2013, Patient A filled concurrent prescriptions from Respondent for both Zolpidem tartrate and Temazepam.

33. On or about February 5, 2013, Respondent saw Patient A and ordered a urine toxicology drug screen, which did not include testing for alcohol. Although it was noted in the patient's chart that a "pain contract" was done, there was no copy of a pain contract in Patient A's records. Respondent noted stopping the Norco and continuing prescriptions for Gabapentin, Methadone, and Ibuprofen.

34. On or about March 5, 2013, Respondent saw Patient A and refilled the prescription for #180 Methadone HCl 10 mg. and continued Ibuprofen 800 mg. Patient A was to follow-up in four weeks, to attend the chronic pain management support group. Respondent made a note under "depression" that appears to indicate that Gabapentin was to be replaced with Temazepam 30 mg. at bedtime, although neither drug is indicated for treatment of depression. Respondent, however, did not stop the Gabapentin but actually increased the dose of Gabapentin from 100 mg. to 300 mg. Respondent's chart note for the visit was not signed until March 16, 2018.

35. From March through May 2013, Patient A continued to fill prescriptions from Respondent for Methadone, Temazepam, and Zolpidem tartrate.

36. Patient A's next, and last, visit with Respondent was on or about July 2, 2013. This visit was focused on the patient's shoulder pain and numbness. The patient reported being seen and getting medications from a physician in Lake County. Respondent noted that the patient reported drinking 1-2 beers a night. It was noted that the patient said that the Methadone was making him sick and that the Seroquel was not working as well, wanted to go back to taking Temazepam. Respondent appears to have prescribed (restarted) gabapentin for Patient A. It is mentioned under the treatment plan for chronic pain but without an explanation for why it was stopped and restarted. Respondent prescribed #180 Methadone HCl and wrote a prescription for Temazepam, without documenting medical indications for these prescriptions. Respondent also prescribed #90 Gabapentin 300 mg. with three refills, #90 Ibuprofen 800 mg., and Seroquel 100 mg. and issued a new prescription for #30 Lunesta with three refills. The patient was to follow-up with a visit in four weeks. Respondent's chart note for the visit was not signed until July 9, 2013.

37. At an interview during the Medical Board's investigation, Respondent stated that she thought that, at the July 2, 2013 visit, Patient A's reported nausea from Methadone was related to his drinking alcohol and that his gastritis was also related to alcohol abuse.

38. On July 4, 2013, Patient A, at age 55, was pronounced dead due to acute methadone toxicity, per the coroner's investigation.

39. Respondent's overall conduct, acts and/or omissions, with regard to Patient A, as set forth in paragraphs 18 through 38 herein, constitutes unprofessional conduct through gross negligence and/or repeated negligent acts, and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234, subdivisions (b) and/or (c), and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient A as follows:

a. Respondent failed to adequately monitor Patient A while prescribing controlled substances and other prescription medications with synergistic sedating properties in a patient

with a substance use (alcohol) disorder, which constitutes an extreme departure from the standard of care.

b. Respondent prescribed Methadone to Patient A, in combination with Gabapentin and benzodiazepines, with the knowledge of Patient A's continued use/abuse of alcohol, without clearly documenting treatment goals and objectives, which constitutes an extreme departure from the standard of care.

c. After Respondent stopped prescribing benzodiazepines in September 2012 to Patient A because of his struggles with alcohol, Respondent later prescribed a benzodiazepine without documenting a medical indication and without a further warning to the patient about the risks.

d. During the course of treatment, Respondent did not document having any discussion with Patient A about the risks of overdose and death with taking the combination of prescribed medications such a methadone, gabapentin, Ambien, and benzodiazepines.

e. During the course of treatment, Respondent failed to document counselling Patient A on the risks of his medication profile in combination with his use of alcohol, particularly the dangers of a potential overdose and death.

f. Respondent prescribed different sleep medications, such as benzodiazepines, Gabapentin and Ambien, without documenting any discussion with the patient about sleep hygiene or about other non-prescription drug-type treatments. Respondent also failed to clearly document the medical indication for the prescribing of the different sleep medications, whether the medications were being prescribed for sleep or for chronic pain.

g. When Respondent became aware that Patient A was receiving prescription medications, controlled substances, from another physician, Respondent failed to appropriately respond, such as with closer monitoring.

h. During the course of treatment, when Respondent became aware that the patient was craving or actually consuming alcohol while taking the combination of prescribed controlled substances with synergistic sedating properties, Respondent did not perform random toxicology testing for alcohol prior to prescribing more opioids and benzodiazepines.

i. Although Respondent referred Patient A to psychiatry, Respondent did not discuss or appear to consider prescribing antidepressants to Patient A.

j. At the last visit in July 2013, Respondent prescribed a high dose of Methadone despite the patient reporting that he had recently received controlled substances from another physician and without consulting the CURES. Respondent also prescribed Methadone even though the patient reported that it caused him nausea.

k. In 2013, Respondent did not consult the CURES database to monitor Patient A's receipt of controlled substances prescriptions.

l. During at least 2013, Respondent continued to prescribe controlled substances without adequate follow-up.

m. There was no copy of a pain management agreement in Patient A's medical records.

n. Respondent often did not timely write her entries in Patient A's medical records.

o. During the course of treatment, Respondent did not obtain objective measurements to determine whether Patient A was consuming alcohol, such as a toxicology or a liver function test. Respondent also did not provide treatment recommendations or referrals for alcohol cessation, such as referral to a substance abuse treatment specialist or to AA.

p. In March 2013, Respondent stopped prescribing gabapentin without documenting an explanation or a medical indication for her treatment plan.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate Medical Records (Patient A)

40. Respondent is subject to disciplinary action for unprofessional under section 2266 for failing to maintain adequate and accurate records for Patient A. Paragraphs 18 through 39 are incorporated herein by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 86620, issued to Jennifer Ann Wilson, M.D.;

2. Revoking, suspending or denying approval of Jennifer Ann Wilson, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Jennifer Ann Wilson, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 11, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2018201631